

Medication Monitoring Committee Minutes

PROGRAM: _____

PLEASE LIST ALL RU NUMBERS COVERED BY THIS REPORT: _____

(If this report covers more than one program, please identify the programs on the screening tools)

Committee Members

Chairperson

Members

Discipline ☒ **Present**

Meeting

Date: _____

Time: _____ to _____

Place _____

Reporting Period

Year: _____

☐ Jul 1 – Sep 30

☐ Oct 1 – Dec 31

☐ Jan 1 – Mar 31

☐ Apr 1 – Jun 30

Description of Activities

Old Business

_____ Number outstanding variances from last MM Committee Meeting (see McFloop form)

_____ Number of variances requiring follow-up

New Business

_____ Number of records screened this meeting by ☐ County Pharmacy
Or by ☐ MM Committee

_____ Number of variances identified and requiring follow-up

_____ No medication monitoring done at this site(s)

Signature
Medication Monitoring Chairperson or Designee

Date